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WEST'S LECTURES ON DISEASES OF WOMEN, SIXTEEN PAGES.

CLINICS.

HOSPITAL NOTES AND GLEANINGS.

Injuries of Brain and Nervous System.—A curious but instructive case recently in St. Bartholomew's Hospital has just ended fatally. The patient was under the care of Dr. Burrows, with what appeared to be apoplexy, attended with well marked paralysis of one side of the body. At the inspection after death, the internal carotid artery of the side opposite to the paralysis was found totally occluded or obliterated by a firm fibrinous clot. The preparation, with the clot extending into the middle cerebral artery (which artery, it will be remembered, passes along the fissure of Sylvius, and is distributed to the corpus striatum), is preserved in the museum at St. Bartholomew's. The corpus striatum, in a word, must have died for want of blood.

In a very suggestive case in Guy's Hospital, Dr. Gull drew attention during the month to the character of the paralysis, which seems to bear out rather unexpectedly the views of M. Brown Séquard, alluded to in Mr. Lawrence's case in the *Association Journal* of November 1st. The patient has loss of sensation in one arm, loss of motion in the other; bearing out the supposition that the nerves of sensation cross in the cord, and that some disease at one side of the cord produced paralysis at that side—want of sensation at the opposite side.

A very remarkable case of fracture of the skull has been also in Guy's Hospital, under the care of Mr. Hilton. One seldom sees an instance (at first all but hopeless) of such apparent destruction of some of the most delicate parts of the cerebral hemisphere, yet followed by the most perfect restoration of health. There seems to have been a crack or smash of the bones at the left side of the head, at the coronal suture, with a large clot of blood resting on the brain, which Mr. Hilton removed. The young man received a terrible blow in a factory from a fly-wheel. He had complete loss of vision at one side, and strabismus,

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as if some part of the brain about the crus cerebri, with the third nerve, as well as the origin of the optic itself, had suffered injury. The parts are now completely healed over, but the pulsation of the brain is quite perceptible. The patient, in fact, leaves Guy's in perfect health, and quite stout, from the attention he had received while under treatment.

There has been a case of compound fracture of the skull in the Westminster Hospital, of no immediate pathological importance, in comparison with that of the case under the care of Mr. Hilton, at Guy's. The miserable circumstances of the attack on the man are already familiar to many newspaper readers. The man seemed to go on for several days very well, and then died of pyæmia.

With reference to Mr. Hilton's case, and the blindness of the boy, Mr. Swan has beautifully shown very recently that a true visual tract, originating from the anterior angle of the thalamus, proceeds to a special convolution *at the summit of the brain*, quite distinct from the tractus opticus, and affording the principal means by which the optic nerve communicates with the convolutions of the brain and the intellect (this part was injured in this boy); that the optic nerve, in fact, has a compound nature. In birds, the optic nerve is curiously blended, Swan says, with the involuntary or purely sensational part of the brain, rendering this part of the brain peculiarly serviceable by associating the eyes with respiration in a long flight, and preventing the fatigue of vision which must otherwise occur from constant voluntary strain on the attention. The retina, it is curious, is more distinctly related with the par vagum, which explains many of those sympathies with the stomach in dyspeptic diseases familiar to the practitioner. The perfection of vision in animals is not in any proportion to the size of the brain or visual apparatus. The larger, however, the true visual tract, and the more extensive the convolutions of the brain, the more is there of intellectual association, as in man.

Mr. STANLEY has a striking case in one of his wards at St. Bartholomew's Hospital —a patient who was suddenly struck with intense deafness of both ears, from slight concussion of the brain. Acting on the idea that hemorrhage into the fourth ventricle, or some lesion in or about the cochlea or calamus scriptorius, had taken place, Mr. Stanley ordered mercury in full doses, with bleeding, to be followed up by the use of iron. The patient is recovering; and probably some slight apoplectic clot is in process of disintegration.

Mr. BOWMAN has under his care two ophthalmic cases, one apparently of amaurosis, but which the ophthalmoscope showed to be a deposit of scrofulous matter in the retina: it is already yielding to treatment. The second case is more confirmed, though the man can distinguish light from darkness. The chief peculiarity of the case, however, is that, along with the probable affection of the commissure of the optic nerves, he complains of a peculiar want and error of the sense of smell. Cases such as these are very rare in practice.—*Assoc. Med. Journ.*, Dec. 6, 1856.

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Tracheal Tube, long worn after Tracheotomy.—A man on whom tracheotomy had been performed about two years ago by Mr. BIRKETT, at Guy's Hospital, under very urgent circumstances, accidentally again came under observation in the same hospital the other day. He was discharged, still wearing the tracheal tube, and has continued ever since to do so. It was retained entirely at his own wish, and as a precautionary measure, as he could breathe very fairly without it. At the time of the operation he was pulseless, and, to all appearance, quite dead from dyspnœa; and such was his horror of a repetition of the circumstance, that he insisted on being allowed to keep the tube in. The original disease was inflammatory œdema of the glottis, supervening on chronic syphilitic disease; and on the morning of the occurrence he had been sufficiently well to be allowed to leave another hospital of which he had been an inmate. There is, therefore, reason to believe that no very great amount of ulceration or cicatrization existed. He is now in excellent health, and breathes sufficiently well through the larynx to allow of the tube being worn covered over by his cravat. When it is so covered he can speak with sufficient clearness to be well understood, and even to be heard at some distance. He states that he has had some colds on the chest recently, but not, he thinks, either more frequently or of greater severity than he used to be liable to before the trachea was opened. The case adds

another to the list of several which we have recorded, in which tracheal tubes have been worn for long periods, not only without inconvenience, but with great comfort. In some cases, undoubtedly, the admission of cold air directly into the trachea is productive of liability to bronchitic attacks of more or less severity, but these seem quite exceptional. Very probably the adaptation of some folds of wire gauze, on the principle of Jeffrey's respirator, might even in these cases obviate the inconvenience.—*Med. Times and Gaz.*, Dec. 27, 1856.

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Empyema and Puncture of the Chest.—There is a case (a lad named Marsh) under Mr. LLOYD's care in St. Bartholomew's, well worthy of attention as an example of some of the events of empyema. He has been under our observation in different hospitals for nearly three years. In the first instance, he was a remarkable example of immunity from constitutional disturbance, while one pleural sac was full of pus. Admitted into St. Bartholomew's Hospital within a few weeks of the original pleurisy (the symptoms of which had been very slight indeed), he was so well as to be able to go up and down stairs and assist the nurses in carrying things for the other patients. His left chest was perfectly dull, but a large majority of those who saw him expressed the most confident opinion that the fluid could not be other than serum, or he must show greater signs of ill-health. While in the hospital he had scarlet fever, went well through it, and recovered well. He left the hospital *in statu quo* as regards the chest, and returned home to assist his father, in work as a bricklayer! About six months later, however, a proof of the correctness of the diagnosis held from the first by Mr. Lloyd and some others, he suddenly began to expectorate pus freely. This continued, and afterwards the matter made its way through an intercostal space, and an external opening was made. This repeatedly healed up, and was repeatedly reopened, he remaining throughout, in spite of the profuse discharge, in fair health. He was under Dr. Peacock's care in the City Hospital for Chest Diseases for some months. A week or two ago, Mr. Lloyd made a free opening into the chest, and there seems a fair chance of the cavity being emptied, should he have strength to survive the process. A case illustrating the same point, as regards the extreme obscurity of early symptoms, is under Mr. Hutchinson's care as an out-patient at the Metropolitan Free Hospital. A little girl, aged 4, was attended throughout a feverish illness by a parish medical officer, who told her mother that she had remittent fever. Her mother was positive that throughout this she never complained of pain in the chest. Not regaining her strength, she was taken to a very excellent and experienced physician, who heard the history, and seeing nothing to lead him to the chest, did not make an examination of it. She had been under his care about a month, when a large fluctuating swelling becoming apparent in front of the chest, she was sent to Mr. Hutchinson, to have "a burrowing abscess under the pectoral muscle opened." A few taps on the chest soon rectified this diagnosis, and showed that the pleural sac (the left) was distended with fluid, and the heart pushed over to the right of the sternum. Within a day or two, a second collection of matter externally showed itself, and both were opened. Since then (about two months) the lower puncture has continued to discharge, and the pleura is now fast emptying itself. The child's health is fair, and steadily improving. A case similar to this, which we mentioned eighteen months ago as under the care of Dr. Ramskill and Mr. Hutchinson, has since ended in complete recovery. The patient, a little boy of 10, is in excellent health, the fistula soundly closed, and the chest but little contracted. —*Ibid.*

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Epithelial Cancer of the Nose; and its Diagnosis from Rodent Ulcer.—Long before the histological diagnosis of cancer was studied, it was a matter of remark among experienced surgeons, that those forms of the disease affecting the nose, eyelids, and forehead were usually of very slow progress. This is now explained by a knowledge of the circumstance, that the form of ulceration to which, as quite incurable, the name of malignant might fairly be given, is, nevertheless, not a true cancer. We are speaking of a disease perfectly distinct from all the forms of lupus, and which none but the ignorant could confound with them. It is the disease described by Mr. Paget, and before him by Lebert, as the "Rodent Ulcer." The cavity formed by this disease resembles often very exactly that of an open

scirrhus; but more frequently it is not nearly so deep. It has a sinuous border, thickened, elevated, and often of stone-like hardness. From the appearance of epithelial cancer it differs markedly in not having any warty growths whatever about its borders or surface. If cut away or destroyed ever so freely by caustics, the cicatrix never, so far as the writer's experience goes, remains healed more than a few months. Its spread is sure, but remarkably slow, and generally nearly painless. It never causes the glands to enlarge, nor does the patient become cachectic, or lose strength. Under the microscope its tissue shows only the forms of cell growth common in the edges of indurated ulcers, and nothing at all resembling those of any kind of cancer. It is decidedly a rare disease; and our own experience, which has included a very large sphere of hospital observation, does not supply us with more than a dozen or eighteen cases. Speaking from general impressions, we should say, that on the parts named, *i. e.*, the inner angles of the eyelids and the nose, it is of about equal frequency with epithelial cancer. Its duration before it causes death may be twelve or fifteen years, and sometimes even more. In its spread it involves all parts, lays bare the bone, opens the nostril, etc., and in the cases in which we have known death to occur, the fatal event has been from hemorrhage. We have seen but two cases in which the rodent ulcer has its seat on other parts than the face, and in both of those it affected the female genitals. We make these remarks *apropos* of an interesting example of true epithelial cancer of the nose now under Mr. Cock's care in Lazarus ward, Guy's Hospital. The patient, a Welshman in robust health, aged 56, noticed a spot on his nose in February last. He scratched it, and ulceration commenced, which spread so rapidly that Mr. Cock was compelled to excise the entire organ, although it was only about five months from the commencement. No glands had as yet enlarged noticeably, but the sore had been the seat of lancinating pain of some severity. In the rapidity of its spreading, the case offers a marked contrast to the examples of rodent ulcer of the same part.—*Ibid.*

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Lead Poisoning.—A case was admitted into the clinical ward at Guy's, last week, under Dr. Addison's care, which presented some features likely to have misled in diagnosis. It was that of a pale exsanguined man, who had suffered from head symptoms, with failing power in the limbs, irregular pains about the epigastrium, &c., but whose chief complaint was of palpitation of the heart. He was stated to have once had a fit, and at first sight the idea suggested was that there was cerebral mischief consequent on cardiac disease. In inspecting the tongue, however, Dr. Addison noticed a blue line on the gums, and on inquiry it appeared that the man had been working in red lead, and that he had suffered much from constipation. The arms, it now came out, had been more affected by the loss of power than the lower extremities. Dr. Addison ordered the iodide of potassium and expressed a confident opinion that most of the symptoms, if not all, would prove to have depended on the impregnation of the system with lead. He related some instructive cases which had occurred to him in private, illustrative of the necessity for being constantly alive to the possibility of symptoms of supposed spinal or cerebral disease being in reality of this nature. A conversation ensued in the clinical room, respecting the explanation of the earlier occurrence of paralysis from lead in the arms than in other parts. Dr. Addison said that this was in his experience a constant event, and occurred equally in cases in which poisoned water had been taken as in those in which, as in painters, the lead had been absorbed by the skin, and mostly by that of the hands and arms. He declined to give any opinion as to its explanation, but mentioned that Dr. Lloyd had broached a theory to the effect that it was from the power possessed by lead of inducing contraction of the arteries, those of the upper extremities being supposed to be proportionately smaller than those of other parts. Dr. Todd's ingenious suggestion is, that it results from the more constant use of the arms, and from the consequent increased rate of nutrition of their muscles.—*Ibid.*

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On the beneficial Effects upon Intractable Strictures of opening the Urethra behind them.—The benefits of the plan of treating bad strictures by procuring a free escape for the urine behind the strictured tract has been well illustrated by a case now under the care of Mr. Cock, in Guy's Hospital.

The end referred to may be secured either by puncture of the bladder, or by opening the membranous urethra, preference for one or the other mode being often optional with the surgeon. Of course, when no retention has occurred, and the bladder is kept empty, puncture of it cannot be resorted to; and in this class of cases, as well as those in which the perineum is the seat either of abscesses or sinuses, the perineal operation is to be preferred. The clinical fact on which the practice is founded is, that strictures, when once relieved of the irritation of the urine passing over them, spontaneously soften down and dilate. The plan, although much ridiculed by some, is a great favourite with several of our most practical hospital surgeons, among whom we may mention Mr. Cock, Mr. Wormald, and Mr. Simon. Mr. Wormald terms it giving "the diseased urethra a holiday," and is very warm in his commendations. Mr. Cock and Mr. Simon we have often seen resort to it. In cases of impassable stricture, its advocates regard it as far safer practice than the attempt to cut through the stricture without a guide, a procedure acknowledged to be one of much difficulty and uncertainty. Mr. Cock's case referred to may be briefly outlined as follows: A man in fair health, aged 30, had been for five years the subject of a long and most intractable stricture. His penis, etc., at the time of admission, was seamed with scars of incisions made for the relief of extravasation, and he stated that he had repeatedly suffered attacks of retention. The urine merely dribbled away, and there were numerous fistulæ in the perineum. After some weeks' patient treatment, Mr. Cock still found himself unable to pass the smallest instrument. The mass of induration around the urethra was very large. The man was now put under chloroform, and with a straight-bladed knife Mr. Cock opened the urethra by a single plunge,* just anterior to the prostate. No staff was in the urethra at the time, and no attempt whatever was made to divide the stricture. A female catheter was passed by the wound into the bladder and retained a few days. No urine whatever flowed by the penis for upwards of a fortnight, and at the end of this time a No. 5 catheter was pretty readily introduced through the stricture. No case could better prove the principle that strictures, when relieved from irritation, do really soften and spontaneously dilate. There is, indeed, whatever some may have held, nothing surprising in the circumstance that they should do so. In cases of Amussat's operation, performed for stricture of the rectum, the latter has been known to dilate afterwards very considerably, and the effect of tracheotomy, in relieving chronic laryngeal disease, is well known to all surgeons.—*Med. Times and Gaz.*, Dec. 20, 1856.

* The term "plunge" may possibly be misunderstood. All that it is intended to imply is, that the knife should be pushed steadily on in the median line, until the urethra is reached, and that there should be no side cutting. The fore-finger of the left hand should be in the rectum, just touching the anterior edge of the prostate, and should serve in a certain sense as a guide to the knife. The making but one cut with the knife secures that the wound shall be of conical shape, its apex being the urethra. The circumstance that the urethra is dilated behind the stricture much facilitates the finding of it. The careful keeping the knife in the median line is the one important point in the operation.

LECTURE.

Lecture on Puerperal Fever. By W. Tyler Smith, Accoucheur to St. Mary's Hospital, and Lecturer on Midwifery, &c. (Continued from page 9.)

Gentlemen: In my last lecture, I stated briefly the evidence and facts which favour the view that all the different forms and manifestations of puerperal fever depend on a specific poison, arising in some instances sporadically; in others prevailing epidemically; sometimes due to the zymotic influence present in erysipelas, typhus, gangrene, surgical fever, and some other diseases; communicable from patient to patient by the attendants; and whose earliest known effect is a disordered state of the blood of the childbed woman. I now proceed to describe the different secondary disorders traceable to the puerperal poison.

In the adynamic form of puerperal fever, the effects of the poison are seen in their most terrible and virulent form. This type of the puerperal disease has prevailed in the most ravaging epidemics, and also in those outbreaks in which the contagious spread of the disorder has been most demonstrable. Occasionally, patients have been struck by the disease during the course of labour, or within a few hours after parturition. In other cases, two or three days have elapsed before the invasion of the disease. In the worst cases, patients

become at once delirious or lethargic, the pulse being very rapid, from 120 to 140 in the minute, and feeble. Occasionally, acute pain is complained of, but more frequently there is in the worst cases little suffering beyond a feeling of indescribable anxiety and depression; sickness and vomiting of coffee-ground matter sometimes distresses the patient. The countenance is commonly sunken and dusky, or deeply pallid, with the dark circle round the eyes strongly marked. The skin is not above the usual temperature, but covered with clammy perspiration. Tympanitic distension of the abdomen rapidly supervenes. Rigors or shiverings may or may not be present. There is little or no sign of reaction, and in the worst cases the patients die in a state of collapse within a short time from the first seizure. Of 88 cases recorded by Dr. Collins, death occurred in 2 cases in 24 hours, in 1 in 27 hours, in 1 in 36 hours; 9 died on the second day, and 15 on the third, so that 24 perished in less than 72 hours. Dr. Ramsbotham states, in the worst cases this disease is more rapidly fatal than any other disease met with in this country, except cholera. Mr. Hey mentions a case in which death followed in less than eighteen hours.

When, from the less virulent action of the poison, or the strength of the patient, the disease is more protracted, the same symptoms are present, but in a milder form and degree. The invasion of the disease generally begins on the second or third day, and is commonly ushered in by shivering. There is in the earlier stages increased heat of skin. The tongue is sometimes coated, at others red; but, as happens with every variety of puerperal fever, cases are sometimes met with in which, from the commencement to the termination, the tongue remains tolerably clean. The prostration is less profound, and there is pain in the abdomen. Profuse sweating is a very common and distressing accompaniment of the disorder. In some cases this is so strongly marked, and constitutes so large a part of the disease, that Dr. Blundell described it as a distinct form of puerperal fever, under the name of hidrosis. The sweat and the breath are very often accompanied by a sweetish pus-like odour. The sweating of puerperal fever does not diminish the secretion of urine, nor does it abate the quickness of the pulse. An intolerable thirst prevails, and the patient drinks immense quantities of whatever fluid she may be allowed. Dark spots, or ecchymoses appear upon the wrists or other parts of the body. After two or three days, profuse diarrhœa occurs, but though it often appears to be critical in its nature, it brings little or no relief, and the patient is harassed by frequent dejections and vomiting. The lochia are commonly but not invariably suppressed. More frequently, the breasts become flaccid without secretion; but this is not always the case. The pain is often intermittent, even in cases where it is most severe, sometimes giving the attendants and the medical practitioner the hope that it may be of the nature of after-pain. In some of these cases the mind is remarkably clear, until towards the termination of the disorder. One of the most constant and distressing symptoms is tympanites. This comes on more rapidly, the more acute the disease may be, and soon rises to such a height as to interfere with the action of the diaphragm and heart. The patient may, in a few hours, become larger than she was before delivery. Considerable quantities of flatus may be discharged, but no diminution in size is perceptible, the distension appearing to depend on an immense secretion of air by the mucous membrane, with paralysis of the muscular coat. In the course of the disease, obscure symptoms of uterine inflammation, with enlargement of the organ, or of peritonitis, pleuritis, or pneumonia, are met with. When the disease proceeds to a fatal termination, the patient succumbs to exhaustion, the action of the heart becoming more frequent and feeble, congestion of the lungs, or effusion into the pleural or pericardial cavities takes place, and low delirium or coma is present for some time before dissolution. In the rare cases, which terminate favourably, the sweating, purging, or diuresis, appears to relieve the patient, and she slowly recovers from a state of great debility, remaining long afterwards in a condition of extreme debility both of mind and body. In comparatively rare cases, the chief symptoms of the disease are gastric, bilious, and enteritic irritation, but these are amongst the more favourable forms of puerperal disease.

The morbid changes met with after death are very various. In the most rapidly fatal cases nothing has been met with beyond non-coagulability, thinness, and black-

ness of the blood. The blood in these cases resembles that of persons killed by lightning or hydrocyanic acid. There may be no signs whatever of any local inflammation, or disease of the uterus or other organs. In the less virulent and more protracted cases, purulent infection of the blood has been detected, and pus has been found in the veins and other structures of the uterus. Congestion of the lungs, gangrenous abscess of their organs, or effusions of mixed pus, serum, and lymph into the pleuræ, have been observed. In some cases, spots of ulceration in the stomach and intestines, or purulent collections in the liver and kidneys, are recorded. Abscesses in the omentum have been frequently found, so have effusions of sanious pus and feebly organized lymph in the peritoneal cavity, particularly about the uterus and its appendages. The internal surface of the uterus and the muscular structure have been found softened and in a state approaching to gangrene, particularly the posterior part of the organ.

It has been mentioned that sporadic cases of puerperal disease are sometimes caused by the absorption of sanious lochial discharges, or the decomposition of coagula or portions of retained placenta within the uterus. There is also another mode in which sporadic puerperal fever may occur. There is some peculiarity about the state of constitution which obtains in pregnancy and parturition, tending to assimilate numerous other affections to the puerperal type. It may be seen, that in the case of a healthy pregnant woman attacked with smallpox or scarlatina, before abortion or premature labour is produced, the disease begins to assume the puerperal type. At any other time than after parturition, the presence of putrid matter in the uterus does not excite any great constitutional disturbance, as witnessed in the case of polypi removed by ligature. Any inflammation of the os or cervix excited by a difficult labour, or peritonitis caused in the first instance by the violent contractions of the uterus, has a strong tendency to run into puerperal fever. After the Cæsarean section, the patient suffers from an almost exact likeness of puerperal fever. Dr. Simpson very ably draws a comparison between puerperal and surgical inflammations and fevers, and refers this similarity to the resemblance which exists between the uterus after labour and a wound after a surgical operation. No doubt this is true to a great extent, particularly as regards the occurrence of phlebitis. But there is in the pregnant and parturient woman a state of constitution which predisposes her to the formation of some virus or poison, capable of producing the puerperal type even before delivery, or even before the commencement of labour. This is the case after mechanical injuries of the gravid uterus. It is observed, in cases of peritonitis, pleuritis, or any other visceral inflammation occurring during pregnancy. Before the uterus has been excited to expel its contents, there is an approach to the peculiar puerperal type of disease. If a gravid woman be attacked with erysipelas, she suffers from the symptoms of puerperal fever or inflammation before the birth of the child, and the infant may, when born, be affected with erysipelas, and die within a few hours after birth. Thus, then, it seems capable of demonstration that, apart from the state of the internal surface of the uterus after parturition, and especially that part of it from which the placenta has been separated, there is in the habit and constitution of the gravid woman, some peculiarity which, under numerous circumstances, produces the virus or poison which gives their characteristics to the multiform varieties of puerperal inflammatory and febrile disease. Amongst the predisposing causes of puerperal fever in any of its forms, anxiety of mind and depressing emotions during pregnancy or at the time of labour hold a very prominent place. This is strongly insisted on by Dr. Fleetwood Churchill and many other writers. Undoubtedly this cause is a main agent in the production of some of the sporadic cases of this disease. Dr. Churchill observes: "Several of the worst cases I have seen were mainly attributable to this cause."

In many cases of puerperal fever, peritonitis of a more or less acute form constitutes the chief part of the disease. In some epidemics, inflammation of the peritoneum has been so universal as to give rise to the opinion that peritonitis formed the essence of puerperal fever, and puerperal peritonitis and puerperal fever came to be used as almost synonymous terms. This was very much the state of medical opinion up to the time when Guthrie, Bouillaud, and Dr. David Davis initiated the doctrine of phlebitis and purulent affection of the blood, so ably

and laboriously worked out by Dr. Robert Lee. Recent outbreaks of the disease have not manifested the peritonitic type so strongly as previous epidemics, but cases not unfrequently occur, in which the peritoneal disorder is the chief local manifestation of disease.

In puerperal peritonitis, or puerperal fever with peritoneal inflammation, the disease usually commences within two or three days after parturition, and seldom longer than a week after labour. Cases are on record, in which it has commenced before the beginning of labour, or during the course of parturition. I have already referred to the influence of contagion and infection in producing this form of disease. Patients with easy labours, and without a sign of inflammatory disorder, may have puerperal peritonitis as the result of contagion or infection, when exposed to erysipelas, gangrene, or any of the disorders mentioned in connection with the production of puerperal fever. It may also arise from injury of the peritoneum during the course of violent labours, or from exposure to cold. When caused in these modes, it is almost universally converted into the febrile puerperal type. In some cases, it is an extension of disease from the parietes or internal surface of the uterus, and in others it is a result of uterine phlebitis. The disease may involve the whole peritoneal membrane, or it may be localized in the neighbourhood of the uterus, Fallopian tubes, and ovaria.

The symptoms of puerperal peritonitis are generally in stronger relief than the symptoms of any other form of puerperal fever. Tenderness, pain, and exquisite sensibility of the abdomen to the touch, particularly in the neighbourhood of the uterus, is generally observed. Yet pain is not always present. On the contrary, it is entirely wanting in some of the most rapidly fatal cases, and where post-mortem examinations have proved peritonitis to exist. Dr. Ferguson found that out of 173 cases, this symptom was absent in 19. The pulse is invariably rapid, remaining throughout the course of the disease at from 120 to 140. This is the symptom which in every variety of puerperal fever never fails of expressing truly the condition of danger. It has often been remarked, that whatever the other indications may be, the puerperal woman is never safe whose pulse rises steadily above 100. In puerperal peritonitis, the pulse is quick from the termination of labour, and it has been observed that where the disease is threatened, the subsidence of the circulation which is natural after labour does not take place. This rising of the pulse is the earliest symptom of peritoneal inflammation. Before the commencement of pain, rigor or shivering almost invariably occurs. Sometimes it does not amount to more than a prolonged creeping over the surface of the body; at others, it is so marked that the teeth chatter, and the patient asks to be held in bed, so violent is the muscular shuddering. While the rigor is most distressing, the surface of the body is little if at all below the natural standard. The state of the tongue is variable—sometimes red at the edges, with a white streak in the centre, at others coated and red, and sometimes without much decided alteration from the natural state. When the other tissues of the uterus are involved, this organ is swollen, and can be felt distinctly and painfully, until the rising tympanitis disguises it. There are cases in which the uterus attains a very large size, after having contracted subsequent to labour. The tympanitic distension which ensues is often very great, and the swelling of the abdomen is further increased by effusion of sero-pus into the cavity of the peritoneum, when the surface acquires a peculiar doughy or boggy feel. Sickness is very constantly present in this disease, and adds greatly to the suffering of the patient, from the compression of the abdomen by the efforts at vomiting. Dysuria is complained of, and the urine is scanty and high-coloured. As the disease progresses, purging commonly supervenes, the motions becoming dark and offensive towards the last. Throughout, the breathing is short and painful, and cephalalgia is often present. Beyond this, the brain is frequently unaffected until the close of the disease approaches. The physiognomy is from the first distressing and pinched, so as to be almost of itself characteristic of the disease. No one who has ever seen the disease can mistake the indications afforded by the countenance and the pulse. The dark areola surrounding the eyes, the dilated pupil, the glassy surface and bloodless conjunctiva, give a lustrous and unearthly appearance to the eyes in all cases of puerperal fever, whatever the special complication, when the disease is fully formed. Occasionally in this disease there is an ap-

pearance of the sudden transference of disease to the pleura, and, more rarely, to the serous membranes of the brain. When the peritoneal inflammation is chiefly limited to the uterus and its appendages, the symptoms are somewhat less severe, and the pain more local, than in general peritonitis, being felt most distinctly in the iliac regions, and sometimes on one side only. With the local peritonitis, there is generally inflammation of the broad ligaments, the sub-peritoneal cellular tissue, the Fallopian tubes, and the ovaria. Suppuration and abscesses sometimes form in these structures, and in the most favourable cases either burst spontaneously on the surface of the lower part of the abdomen or into the vagina or rectum, or they sometimes admit of puncture and artificial evacuation. A fatal result is almost invariable when pus is formed in any considerable quantity upon the peritoneal surface.

The pathological changes consist of effusions of pus or of lymph, rarely so highly organized as after ordinary peritonitis, sero-purulent effusions and abscesses of the surface of the uterus or its appendages, or of the omentum. In many cases, the uterus is found diseased, the inflammatory disorder having extended from the uterus to the peritoneum, or, in some cases, from the peritoneum to the uterus. Softening of the parietes, patches of gangrene, abscesses in the walls, and collections of pus in the veins of the uterus, are met with.

One of the greatest, if not the greatest, advances ever made in the pathology of puerperal fever consists in the knowledge we have obtained, in recent years, of the existence of uterine phlebitis as a very common and destructive form of puerperal disease. The occurrence of uterine phlebitis and suppuration of the veins in isolated cases had long been known, but no other inquiries, as far as I am aware, have at all equalled the researches of Dr. Robert Lee in this particular department, and it is to his extended investigations that we chiefly owe the establishment of the doctrine of uterine phlebitis as it occurs after parturition. Others have, as I believe, with truth, controverted Dr. Lee's views of the entire dependence of puerperal fever upon uterine inflammation and phlebitis, and it may, I think, be shown, that where phlebitis exists, it is, in almost all cases, an expression of constitutional disorder, and especially of a poisoned or diseased state of the blood, rather than an idiopathic disease. The researches of Dr. Ferguson and others prove that puerperal fever may destroy patients before there has been sufficient time for the occurrence of phlebitic inflammation, and that in such cases no pathological changes beyond a diseased state of the blood are met with. Many facts in the history of puerperal fever prove that before the purulent infection of the blood, believed by Scanzoni and others to constitute the essence of the disease, has taken place, changes have occurred in the circulating fluid, which may in some cases destroy the patient long before the suppurating stage has been reached. The experiments of Dr. Mackenzie, and the cases he has collected, show that healthy obstructive inflammation of the veins, the result of simple traumatic injury, does not result in purulent infection of the blood, but that a morbid state of the circulating fluid is necessary to the production of pyæmia.

Uterine phlebitis generally commences on the second, third, or fourth day after labour, with shivering, or rigor, and a marked increase in the quickness of the pulse, which ranges throughout from 110 to 140 and 150. There is usually pain in the hypogastric, or one of the iliac regions, the pain becoming more evident upon deep pressure. There is also pain in the back, or in one or both hips, extending downwards to the thighs. The pain is generally intermittent, and is sometimes absent for many hours. The patient is usually anxious to be quiet, every movement of the body greatly increasing the pain when this symptom is present. But in a considerable number of cases the pain alone is not so considerable as to indicate the dangerous state of the patient, and in some instances it is absent altogether. The lochia may become offensive at the commencement of the disorder; they may be scanty, or they may remain in normal quantity and quality. The mammary secretion is usually suspended; but in some cases it continues until the patient is exhausted by the progress of the disease. The perspiration is very distressing, and constant, and after three or four days from the commencement of the attack, diarrhœa is generally present. At intervals, throughout the course of the disease, violent rigors are felt, which may be supposed to make successive formations

of pus, or the commencement of inflammation in other organs beside the uterus. The state of the tongue is very variable, and it may be red and glazed, covered by a creamy fur, or scarcely altered from the natural state. The complexion of the patient is at first little altered, except by the presence of a hectic spot on each cheek. The mind is clear, but the speech and movements of the patient are tremulous. The patient often sleeps tolerably well, and frequently expresses herself as feeling better; but her manner is anxious and trembling, thanking those about her so nervously for the slightest attention, that her state in this respect has often been compared to the incipient stage of puerperal mania. The tympanitic distension of the abdomen is not the least distressing symptom, giving rise to hiccup, vomiting, and greatly interfering with the respiration and the action of the heart.

As the disease progresses, the secondary phenomena of uterine phlebitis and the formation of pus within the veins become evident. The patient complains of pains in some joint or joints; swellings appear in the neighbourhood of the articulations, and erysipelatous blushes appear on the skin in different parts of the body. The hips, knees, shoulders, and elbows are the joints most commonly attacked. Large suppurations in the vicinity of the joints occur, or patches of slough or gangrene form at the sides of the erysipelatous blushes. Sometimes the secondary inflammation attacks the eye, especially the left, leading to rapid destruction of the cornea. These external suppurations, however painful and exhausting, are considered somewhat in the nature of crises, and as giving some faint hopes of recovery. Up to this point, up to the time in fact when external suppuration begins, it is acknowledged by the best authorities that we have no positive signs by which we may be sure of the existence of phlebitis. This is stated with great candour by one of the latest and best writers on the subject, Dr. McClintock, of Dublin. In other cases, the secondary inflammations and suppurations are internal, and attack the lungs, liver, kidneys, omentum, or other organs. These complications are more dangerous than the external secondary abscesses. These phenomena cannot exist without the pyæmia of which they are the results, indicating its constitutional effects. When pus is present in the veins, the inflammatory symptoms subside to a considerable extent, and adynamic or typhoid symptoms manifest themselves. It is necessary, however, to distinguish between the low state of system thus produced and the somewhat similar condition which exists in the first instance, when the puerperal virus is very potent, and before any inflammation or suppuration has progressed in the veins. When patients recover, they slowly struggle through the exhaustion produced by the extensive suppurations, and may remain blind or with anchylosed joints to bear witness to the terrible ordeal through which they have passed. When a fatal result ensues, the patient dies with symptoms very similar to those described when speaking of the adynamic form of puerperal fever, or exhausted by the discharges consequent on the external suppurations.

The tendency of the puerperal and other forms of pyæmia to attack the joints, is a very remarkable feature of this affection. Large effusions of pus and sero-purulent fluid are poured out in the joints affected, and the cartilages are often eroded and destroyed to a remarkable extent. No explanation has been given of the reasons why the joints, the eyes, or the serous membranes should be especially selected. I would suggest the probability, that this selection may depend on the nourishment of parts of the eye, cartilages, and serous membranes, by the non-vascular permeation of the tissues by the liquor sanguinis, as explained by the researches of Mr. Toynbee. The diseased liquor sanguinis, or the liquor puris, in purulent infection of the blood, may easily be supposed to affect especially those tissues of the body in which special provisions exist for their permeation by the colourless parts of the blood. One of the earliest, as well as one of the most graphic descriptions of puerperal affections of the joints we owe to Mr. Coulson, who has described the dissection of numerous cases of this kind.

Besides uterine phlebitis, other forms of puerperal inflammation of the uterus occur. That which affects the lymphatic vessels does not materially differ in symptoms, progress, and termination from phlebitis. Inflammation of the muscular tissue and lining membrane of the uterus is characterized by great disturbance of the nervous system, distressing cephalalgia; and is attended by fever of low type. Occasionally the cere-

bral symptoms are so intense as to entirely mask the uterine disease. It is ushered in by the same symptoms as regards rigors, acceleration of the pulse, and state of tongue as those which attend the other varieties of puerperal inflammation. Its tendency is to produce softening, suppuration, and gangrene of the substance of the uterus, and it is one of the most fatal of all the puerperal inflammations.

Before speaking of the treatment of puerperal fever in its varied forms, it cannot be too much insisted on that it is a disease, almost above all others, open to *Prevention* rather than *Cure*. The avoidance of injuries of the uterus or vagina in difficult or instrumental labours, the entire removal of the placenta, and the promotion of a free lochial discharge, with the avoidance of the possibility of inoculating or infecting the puerperal woman with any of the poisons which admit of conversion into the puerperal poison, are of the greatest importance in preventing the appearance or extension of this terrible disease. As regards the actual treatment, nothing can be more different than that which has been most successful, or best borne in different epidemics, and at different places and times.

The opposite extremes of puerperal fever —namely, the peritoneal and inflammatory, and the adynamic—are those which most distinctly admit of positive rules of treatment. In puerperal peritonitis, copious venesection, the free use of leeches, mercurials, opium, fomentations and stupes, or warm poultices to the abdomen, counter-irritation, and mild aperients, are the means upon which we must depend. The bleeding must, however, be prompt to be of service, and its extent must be measured by the powers of the patient and the intensity of the disease. A full bleeding to twenty or thirty ounces at the outset of the disease will do more to relieve the patient than any subsequent treatment. She should be bled in the upright position to incipient syncope, and the bleeding should be repeated in a few hours, or the abdomen covered with three or four dozen leeches. At the same time, calomel with opium or Dover's powder, should be given in repeated doses at small intervals, with a view to the production of ptyalism, or mercurial inunction should be resorted to. When general and local bloodletting have been carried as far as the patient will bear, and when the disease continues, a large blister over the abdomen is of great service. In all cases of puerperal peritonitis, there comes a time, unless the patient has been rapidly destroyed, in which stimulants are required, and this time comes much earlier in puerperal than in ordinary peritonitis. It is only in the most acute forms of puerperal peritonitis that such an active plan of treatment as that now indicated is admissible. In peritoneal disorders of a lower type, depletion must be more sparingly employed, and a tonic plan earlier resorted to.

In the most adynamic cases of puerperal fever, a stimulating treatment must be adopted from the first, and wine, brandy, ammonia, and quinine are required. The only antiphlogistic remedy that can be resorted to in such cases is blistering. In milder, or more mixed cases, a small bleeding at the very commencement is sometimes called for, or the application of a few leeches, but as the patient passes rapidly into the low stage of the disease, support and stimulus become necessary. The treatment is little different from that required in marked cases of typhus.

In phlebitis, the employment of bleeding is a vexed question. Some authorities have strongly recommended early bleeding, and others have opposed it, advocating a tonic regimen, and directing all their efforts to the preservation of as healthy a state of the blood as possible. In one instance in this metropolis, bleeding was tried on a large scale in a lying-in hospital, where venesection was performed on the very first approach of the disease, and the mortality was greater than when an opposite plan was adopted. In the present state of our experience in this disease, bleeding appears to be called for at its commencement, when the pain is acute, and the pulse rapid. But this disease is often so insidious, and its progress attended by such remissions, that it is difficult, if not impossible, to decide on bleeding until distinct evidences of pyæmia have appeared, when bleeding becomes injurious rather than otherwise. As soon as this becomes evident, cinchona, nitric acid, chlorate of potash, ether, ammonia, strong animal broths, and wine, are agreed on by all authorities as the best line of treatment. Pain must be allayed by opiates, and the painful joints bathed with opiate embrocations or a chloroform liniment. When collections of matter are evident upon the sur-

face, they should be opened, and it is believed that the external discharge of pus adds somewhat to the chance of recovery. Congestion of the lungs or brain must be met by sinapisms or blisters, and the meteorismus relieved, as far as possible, by carminatives, turpentine enemata, or the introduction of a tube into the intestinal canal. It is impossible to do more than lay down general principles, and indicate the points of treatment, within the scope of a lecture. A patient suffering from the disease now under consideration will tax all the resources and all the vigilance of the most able and painstaking practitioner.—*Lancet*, Nov. 15, 1856.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Substitute for Cod-liver Oil.—Dr. G. P. Cammah directs attention (*N. York Journ. Med.*, Jan. 1857) to the oily substance taken from the cavities in the head of the spermaceti whale, known in commerce as the head matter, and which he recommends as preferable to the cod-liver oil, on account of being more agreeable to the taste, leaving a pleasant flavor in the mouth, and also being more nutritive and soothing. It is, he says, less apt to disagree with the stomach, and does not cause offensive eructations. The patient may take it either pure, in coffee, or with bread, boiled rice, potatoes, &c. When required, tr. opii camph. and syr. ferri iod. may be added.

Scarlet Fever.—The editor of the *California State Medical Journal* states, that scarlet fever has prevailed to a terrible extent in some of the counties of California.

It has been, likewise, very prevalent, and in a very malignant form in some of our Eastern cities. In New York, during the week ending on the 17th of January, there were 68 deaths from the disease. In Philadelphia, there were 57 deaths from the disease during the corresponding week, and in Boston 21. During the preceding week, the deaths in Boston, from the disease, were 27.

Medical College of the State of South Carolina.—It is stated (*Charleston Med. Journ.*, Jan. 1857) that this institution continues to prosper. The class in attendance, the present session, exceeds that of any former year—amounting to 234 students.

FOREIGN INTELLIGENCE.

New Anæsthetic—Amylene.—Dr. Snow administered the vapour of amylene, on the 13th of December last, in four surgical operations at King's College. It caused an entire absence of pain in all the cases, although the inhalation was not carried so far as to induce complete coma, the patients appearing to be in a dreaming state during the greater part of the time that the operations were going on. There was a little mental excitement and muscular rigidity in the two men, but not more than frequently takes place under the influence of chloroform; and the recovery from the effects of the vapour was very prompt. Dr. Snow had previously given the amylene in several operations on the teeth, performed in the same hospital by Mr. Samuel Cartwright, the dentist to the institution; and he informed us that he had not yet met with sickness in any case, although most of these latter patients had taken their dinners just before coming to have teeth extracted. Amlyne is made by distilling fusel oil with chloride of zinc. Its composition is 10 atoms of carbon and 10 of hydrogen. It is only two-thirds as heavy as water, and it boils at 102° Fahr. The vapour is much less pungent than that of chloroform, and therefore easier to breathe. This liquid was first described by Cahours about fifteen years ago, but has apparently not attracted much notice. We are not aware that it was ever applied by inhalation till Dr. Snow turned his attention to it a few weeks ago, and he is not yet prepared to say whether he will recommend it for general employment. The amylene he has used was made for him by Mr. Lloyd Bullock. It was administered in all the above cases by means of his usual chloroform inhaler.—*Med. Times and Gaz.*, Dec. 20, 1856.

Origin of Erysipelas.—Dr. Thomson, in his last monthly report of the health of Marylebone, gives the following striking evidence supplied by Dr. Corfe as to the origin of erysipelas: "For several years erysipelas constantly occurred (5 cases

within a very brief period) in an accident ward on the ground-floor of the west wing of the Middlesex Hospital, but always on the eastern side of the ward. The ward (Clayton's) is the largest in the hospital, and therefore deficiency of breathing space, a common exciter of erysipelas, was scarcely to be suspected as the cause of the malady. By careful observation it was noticed that the beds most likely to be affected were directly over the common dust-hole of the hospital, which was situated in a vault in the western front area, the effluvia from which escaped and entered the ward by the window. By properly securing the dust-hole the further escape of the noxious exhalations was prevented; but some time afterwards two cases of erysipelas having occurred directly over the vault, it was found that the dust-hole had been accidentally open. Since that period, I am assured that for nearly four years no case of erysipelas has occurred in this ward."—*Ibid.*

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The Effects of Tartar Emetic upon the Muscular System while spasmodically affected by Strychnine.—Dr. Power read a paper on this subject before the Surgical Society of Ireland. He detailed the particulars of a case which occurred under his observation in the summer of 1843, in which strychnine was exhibited in minute doses for a paralytic affection of the extensor muscles of both forearms. The strychnia produced its full effect upon the muscular system, and it was deemed prudent to control it to a certain extent: for this purpose, minute doses of tartar emetic were administered, and in a few hours the spasms became greatly relieved, and at length disappeared. The tartar emetic was therefore discontinued; but after a lapse of twelve hours, during which time there was no tetanic paroxysms, the spasms reappeared, and were again controlled by the antimony. Dr. Power threw out the suggestion, that probably Palmer may have had some knowledge of this effect of tartar emetic, and that he still continued to keep his wretched victim under its influence, both before and all day after the exhibition of the first dose of strychnia, and up to Tuesday evening, until, in fact, within a few hours of the administration of the second dose of strychnia, which caused his death; and that this may have been done with the intention of making or disguising the characteristic spasms.—*Ibid.*

Urea in Pleuritic Effusion in Infants. By Dr. C. Hecker.—The wife of a mechanic, aged 38, applied on account of supposed labour-pains, on July 24, she expecting in the middle of August. For some weeks past, the lower extremities had been œdematous, and the urine contained enormous quantities of albumen. In other respects she was tolerably well, and able to attend to her household duties. On the 30th of July, pneumonic infiltration of the right lung occurred, and the next night rapid delivery took place, without any sign of eclampsia. The child was stillborn, owing to the funis twisting around its neck. The usual appearances seen in stillborn children were observed, especially numerous ecchymoses in the lungs and heart; and the pleural cavities contained an abnormal amount of fluid, without any disease of the pleura being observable. This fluid, which might amount to about two ounces, contained a considerable quantity of urea, crystals of this substance being exhibited under the microscope both in its pure state and in its combinations with the nitrates and oxalates. The mother died of pneumonia the 9th of August. In relation to the presence of urea in the pleuritic exudation in children, Dr. Hecker mentions the case of an infant born September 8, and dying early in October. The left pleura contained three or four ounces of fluid, which furnished crystals of nitrate of urea. There was no accumulation on the right side.—*Med. Times and Gaz.*, Jan. 3, from *Virchow's Archiv.*

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Galactorrhœa.—An interesting case of galactorrhœa recently came under M. Guerneau de Mussy's care. A woman, aged 20, previously in excellent health, was confined with her first child. The secretion of milk was so abundant that she was able to suckle two children besides her own; and after awhile, it flowed away without suction, and inflammation, with abscess, followed. This was relieved, but the breast continued to increase in size; and although the woman had given up suckling, the milk flowed away for some time at the rate of twelve pints per diem. When first seen by the author, several months after her delivery, the daily discharge of milk still amounted to seven pints in the twenty-four hours, and the gland was hard, irregular, and painful to the touch. The woman was feverish and

very thirsty, and much wasted. He ordered cherry-stalk water, containing some bicarbonate of soda, as a drink, and one of the following pills twice a day: Proto-iodide of iron, iron filings, āā gr. xxx, in pil. 20. Besides these, there were ordered twelve sulphureous baths, cold applications to the breast, and general frictions by means of a flesh-brush. This treatment was followed with exactitude, and the woman was quite well in a month.—*Ibid.*, from *Gaz. des Hôp.*

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Rheumatic Tenosynitis.—M. Chassaignac considers that rheumatic inflammation of the tendons is an affection that has not as yet been sufficiently studied. The patient who elicited these remarks recently entered the hospital on account of a rheumatic hydrarthrosis of the right knee, having already suffered from several attacks of rheumatism; so that there could be no doubt of the diathesis being present. There was observed, also, in this patient, on his admission, a painful hypertrophy of the tendo-Achillis on each side. It was not an example of the affection which Velpeau has termed crepitating tenosynitis, and which consists in an inflammation of the sheath of the tendon, and is characterized by a serous effusion, accompanied by a kind of cracking analogous to that which is heard on pressing starch or hardened snow between the fingers. Here it is an affection of the tendon itself; for, on the one hand, the tendo-Achillis has no synovial sheath, and the thickening can only arise from a modification of its proper tissue; and, on the other hand, the hardness was such in this case as could only arise from an increase of size exclusively due to the tendon. The induration proceeded from below upwards, and at one period, the upper part of each tendon having become inflamed, it could be felt hard and tender, as could the foliaceous prolongations it sends among the muscles of the calf—prolongations that could be easily perceived by simple palpation. The induration was attacked by vapour douches, and through their agency the movements, which were at first painful and difficult, have become more free, while the tendons have been rendered more supple, and the hypertrophy has diminished.—*Ibid.*, from *Moniteur des Hôp.*

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Iodine in Dysentery.—Dr. Palm states that during an epidemic of dysentery, when other means had failed, very effectual relief to the distressing tenesmus was given by the following enema: Iod. ℈ß, iod. pot. ℈j, in ℥ij of some slimy vehicle, employed once or twice a day for two or three days; half the quantities being used for children.—*Ibid.*, from *Schmidt's Jahrb.*

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Tannin and Glycerine in Fissure of Anus.—Dr. Van Holsbeck, considering the contraction of the sphincter as the effect and not the cause of fissure of the anus, directs his attention to the latter. He has treated with success several cases in which the fissure has persisted after the division of the sphincter by means of the following application: glycerine, 16, tannin, 1. A more or less voluminous tent is dipped into this, and introduced into the rectum night and morning; and after awhile, the patient can do this for himself. It acts both by the topical influence it exerts upon the fissure, and by its compression (its size being increased) at will, upon the constriction. In order to prevent a relapse, great care must be taken to obviate the occurrence of constipation for the future.—*Med. Times and Gaz.*, Jan. 3, 1857, from *Union Med.*, No. 142.

Distinctive Tests of some of the Varieties of Albumen.—The following remarks are extracted and condensed from a valuable series of chemical tables compiled by T. J. Herapath, which are being published in the *Chemist:*—

All forms of albumen contain nitrogen and sulphur, are soluble in a hot solution of caustic potash, and then blacken the salts of lead; heated with a solution of subnitrate of mercury to 140 deg.—160 deg. they acquire a deep red colour.

1st. *Albumine* is coagulated by boiling, but more readily on the addition of dilute nitric or hydrochloric acid. There are two varieties of it: the first, ovalbumine, the white of egg, is distinguished by its coagulating with ether, and by acetic acid and heat, remaining so at all temperatures; the second, or seralbumine (of blood serum), is not coagulated by ether, and the precipitate with acetic acid only appears on cooling the solution, and redissolves on the application of heat.

2d. *Emulsin*, obtained from the kernels of almonds, and certain species of *pyrus*, is distinguished by precipitating with ordinary

phosphoric acid, whereas ordinary albumen precipitates only with the metaphosphoric acid.

3d. *Fibrin*, distinguished by its power of spontaneously coagulating.

4th. *Caseine*, or *legumine*, obtained from milk, vegetable juices, the seeds of the *leguminosæ*, &c.; it is distinguished from fibrin and albumen by its not coagulating either spontaneously or by heat, and by forming a pellicle, when its solution is evaporated. It is coagulated by dilute acids, which are unable to coagulate albumen.

5th. *Pepsin*, contained in the juices of the stomach. When digested with flesh, &c., at a temperature of 98 deg., it causes the flesh to become soluble in water. It is distinguished from albumen by its solution being precipitated by dilute acids, the precipitate redissolving in excess; and from caseine, by its acid solution not being precipitated by prussiate of potash.

6th. *Hæmatosine*. Its aqueous solution is brownish, and on boiling it deposits a brown sediment, readily dissolving in alkaline solutions with a brown colour.—*Chemist*, No. XXIX.

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Boron.—Not content with the discovery of Aluminium, and its application to useful purposes, WOHLER and DEVILLE have just succeeded in obtaining Boron in a crystalline form. This substance resembles silicon in many respects, and may be looked upon as intermediate between carbon and silicon. The crystals are extremely brilliant; their refractive power is equalled only by the diamond; and it is supposed that our chemists will now be able to prepare a fictitious or boron diamond, which no one but a chemist can detect from the genuine or carbon diamond.—*Ibid.*

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Water Hygiene.—"The tanks for water in India are covered with a green weed," says the *Indian Annals of Medical Science*, for May, "and this at the same time that it imparts a greenish hue to the water, possesses a remarkable power of filtering it, and rendering it sapid and wholesome; for where you have this green weed, you also find small fish and infusoria, which preserve the water also. Sir Charles Napier, inspecting the hill districts of the Punjaub, observing the Bheestees drawing water from one of these tanks, ordered it to be immediately cleaned, and the authorities fearing to remonstrate, the mandate was obeyed. The result was that the water soon turned putrid, and it was not till a fresh crop of duck weed had grown that it became clean and drinkable." When marshes cannot be drained, the best prophylactic of fevers is to plant the marshes with aquatic plants, and such trees as alders and poplars.—*Ibid.*

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Extra Fingers and Toes.—Dr. BERNHARDI had already published an account of a woman who gave birth to a boy in 1851, and to a girl in 1854, each having twelve toes and twelve fingers. This year she has again had a girl also with twelve toes and fingers. The extra fingers have the same direction as the others; but as there is no metacarpal bone, they are articulated with the little fingers. The toes have metatarsal bones.—*Ibid.*, from *Berlin Med. Zeitung*, No. 31.

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Medical Journals in Russia.—There are four medical periodicals in Russia: the *Medicinische Zeitung Russlands* (Russian Medical Times), edited in German by Drs. Heine, Krebel, and Thielmann; the *Gesundheitsfreund* (Friend of Health), edited in Russian by Dr. Eugene Pelikan, and containing original communications and selections from foreign works; the *Zeitschrift für Militair-Medicin* (Journal of Military Medicine), edited in Russian under the direction of Dr. Eugene Pelikan and Dr. Tschitsowitsch, professor-adjoint of the Medico-Chirurgical College in St. Petersburgh; and, lastly, the *Moskow Medical Journal*, edited by Professor Polownin. The *Journal of Military Medicine* appears four times yearly, in octavo, in an edition of four thousand copies; it is extensively circulated to all military surgeons in Russia, at the very moderate price of three silver roubles (about 13*s.* 6*d.*). It contains original contributions, mostly supplied by the professors in the Russian universities and in the medico-chirurgical school at St. Petersburgh, and also by military surgeons, as well as translations of monographs of excellence by German, French, and English surgeons. The original articles are by Pirogoff, Pelikan, Zablotzky, Kieter, Tschitsowitsch, and Platanoff, in St. Petersburgh; by Hubenet and Mazonn, in Kiew, etc. Among the selections from foreign authors, are Nélaton's *Elements of Surgical Pathology*, Forget on *Diseases of the Heart*,

Valentin's *Physiology*, Becquerel on *Hygiène*, Zehetmayer on *Auscultation and Percussion*, Clarus and Williams on *Diseases of the Heart*, Oscar Heyfelder on *False Passages*, J. F. Heyfelder on *Resections and Amputations*, etc.; as well as translations from the smaller works of Köl-liker, Rochow, Luschka, Vierordt, Frerichs, Henle, etc.—*Ibid.*, from *Deutsche Klinik*, August 2, 1856.

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School of Physic in Ireland.—At a meeting of the King and Queen's College of Physicians in Ireland, held Nov. 15th, Dr. CHURCHILL was unanimously elected Professor of Midwifery in the room of Dr. Montgomery, resigned.

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Royal College of Physicians.—Dr. THOS. MAYO has been elected President, in the place of the late Dr. Paris.

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Medical Students.—It is stated that fewer students than usual have entered in Edinburgh the present session; the same may be said with regard to London, where the total number of students amounts to 1,080. —*Assoc. Med. Journ.*, Dec. 20.

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Maternité.—M. DANYAU has been promoted to the office of Chief Surgeon to this hospital, in the place of M. Paul Dubois, who retires on account of age.

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Academy of Medicine.—M. NELATON has been elected a member by a very flattering vote; 60 out of 78 members having voted for him.

M. Poggiale has been elected into the section of Pharmacy, after a close contest.

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Fee to M. Paul Dubois.—There has been much speculation as to the amount paid to M. P. DUBOIS for delivering the Empress of the French. From a paper published in Paris as to the expenses of the Emperor last year, it appears that M. Dubois received nearly fourteen thousand dollars.

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Dr. Southwood Smith.—A private meeting of noblemen and gentlemen has recently been held at Lord Shaftesbury's residence, to consider the best mode of testifying their personal esteem for Dr. SOUTHWOOD SMITH. The mode adopted was, to present a bust of Dr. Smith to some public institution, as a memorial of his services in promoting that course of legislative reform which has laid the basis of an administration to guard and improve the public health; the bust to be executed by Mr. Hart, the eminent American sculptor.—*Med. Times and Gaz.*, Jan. 3, 1857.

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Cooley Trade.—A British merchant vessel, the Duke of Portland, carrying Chinese passengers between Hong Kong and the Havannah, lost 132 Chinese on the passage. What are the horrors of the middle passage in slavers to this? The facts came out at a police court this week, and we trust will lead to further investigation, and more stringent enforcement of the Merchant Shipping act. Well might the magistrate say: "The English flag is disgraced by such traffic." The causes of death were entered in the log as "fever" and "exhaustion." Probably "scurvy" and "starvation" would have been nearer the truth. —*Med. Times and Gaz.*, Jan. 10, 1857.

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Accidental Poisoning.—We noticed last week a case of accidental poisoning by prussic acid. It appears that a druggist's assistant was making up a prescription for a lotion containing prussic acid, and serving castor oil at the same time, and that he put the prussic acid into the castor oil bottle instead of that containing the lotion. Prussic acid was detected in the remains of the castor oil, and in the stomach of the deceased, by Mr. Rodgers; and a verdict of manslaughter has been returned against the druggist's assistant, who has been committed for trial.—*Ibid.*

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Disease in Cavalry Horses.—A letter from Poonah informs us that a very extraordinary disease has attacked the horses of the 14th Dragoons. It resembles the cholera in all respects. Many of the animals are violently purged in the first instance; others are seized with cramp, and die without being purged.

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OBITUARY RECORD.—Died in London, Dec. 24th, in the 72d year of his age, JOHN AYRTON PARIS, M. D., Cantab., President of the Royal College of Physicians, Vice President of the Royal Society, &c. &c. &c.

——in London, Jan. 2, in the 79th year of his age, Dr. ANDREW URE, F. R. S., one of the most eminent chemists of the present day.